Cleveland Clinic | HealthyChoice

Health Visit Form

All sections of this form must be completed and signed by a licensed health professional (MD, DO, NP, PA) from your PCP's office and mailed, emailed, or faxed directly to EHP.

DATE OF EXAM (required)

PROVIDER INFORMATION

Last name: _____

First name: _____ Middle initial: _____

Office: _____

Address: _____

Telephone: (_____) _____

PATIENT INFORMATION (required)

Last name: _____ First name: _____ Middle initial: _____

EHP ID: _____ Date of birth: _____

BIOMETRIC DATA (required)

Height: _____ Weight: _____ BMI: _____ Blood pressure: _____

LAB WORK (required)

If under age 40, all individuals should have a baseline panel. If normal, repeat at age 40. For age 40 or older, cholesterol screening must be within last three years.

Date drawn: _____ LDL: _____ LDL:HDL ratio: _____

CHRONIC CONDITIONS (required)

Check Yes if patient has diagnosis. Check No if screen is negative or there is no patient history

Hypertension	❑ YES	❑ NO	Check Yes if BP > 140/90 or on treatment regimen
Diabetes	❑ YES	❑ NO	Check *(if applicable):* ❑ Type 1 ❑ Type 2 Goals for diabetes are BP <130/80 LDL <100
Hyperlipidemia	❑ YES	❑ NO	Check Yes if LDL >130 or on treatment regimen
Asthma	❑ YES	❑ NO	
Overweight/Obese	❑ YES	❑ NO	Check Yes if BMI is 27 or above
Current Nicotine use	❑ YES	❑ NO	Includes smoking, chewing and/or vaping

I authorize my patient to join the applicable physical activity and/or Coordinated Care Program to help maintain or improve their health status.

Provider signature: _____

Please return by mail to:

Cleveland Clinic Employee Health Plan
25900 Science Park Drive, AC242
Beachwood, OH 44122

Email: ehphc@ccf.org
Fax: 216.448.2053